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SOME LESS KNOWN CLINICAL MANIFESTATIONS OF FILARIASIS

BY

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A great deal has been written in recent years on this helminthic infection with special reference to the possible mode of infection, its epidemiology and endemiology—but very little on its clinical manifestations. To a comparative stranger to tropical medicine the name conveys the causative factor of Elephantiasis Arabum, of unexplained cause of chyluria, chylous ascites etc., and little else. Obstruction to the lymph flow as the main cause of the symptoms was emphasised in the text books of Tropical Medicine. Streptococci were thought to play an important role in the aetiology of the disease. The clinical description was mainly confined to the Elephantoid limb, scrotum, breast etc.,—The huge shapeless limb with the yam like thickening of the skin, with the Eczematoid ulcerations and streptococcal infection was no doubt the result of chronic lymphatic obstruction. On the other hand it would appear to the writer that the Symptomatology of Filariasis is changed a great deal in recent years. Though the lymphatic obstruction type does exist, one rarely sees those stupendous legs, arms, breast, scrotum etc. On the other hand the clinical manifestations appear to be protean, not easily explainable either by the obstruction phenomena or by the invasion of streptococci. The following descriptions are based upon a study of cases where microfilaria have been demonstrated to the exclusion of all other positive manifestations, as it is a well-known fact that the mere presence of microfilaria may be fatuous and that the diagnosis of Filariasis should be accepted when there is no other obvious disease.

Grouping the cases under various systems has been very difficult as a few cases have been merely monosymptomatic. Further, it is hoped that this article will stimulate other observers to come forward with their notes so that a much more comprehensive classification of the Symptomatology may be possible.

A :—Pyrexial type.

This group comprises a large number of patients—mostly young adults —males slightly in excess. The evidence of lymphatic obstruction at times is negligible. The type of fever is not constant. Certain predisposing causes such as fatigue, occasions of stress and strain (*e.g.*, Examination " Wind-up "), constipation etc., precipitate the attack. The course is self limited—helped, of course, by simple assistance to nature and perhaps by the administration of the time honoured Triple-sulph. mixture. Considering the age group picked and the occasions precipitating the attack, this group of cases is economically very disturbing. The diagnosis is arrived at by a process of exclusion of other fevers and the presence of microfilaria in the blood.

Quite apart from this acute type, there are cases on hand where a low grade temperature has persisted for weeks with very few guiding signs— Diagnosis of tuberculosis, Coli infection, fevers due to septic foci have had to be excluded. The presence of Eosinophilia and microfilaria have compelled the writer to diagnose Filariasis. The treatment has been no less troublesome.

B :—Lymphatic Group.

Though more allied to the classical type, yet a good few of the cases under this heading have manifested dissimilarity to merit mention here.

(*a*) In one lot of cases there is recurring adenitis with little fever and little or no evidence of lymphatic obstruction.

(*b*) In a second lot the only evidence of any type of obstruction consists of moderate and slightly painful swelling of the terminal segment of a limb (dorsum of the foot or hand). The event is apyrexial. Often, the patient states that the swelling appeared during nights. Failing to perceive any traumatic cause, the patient attributes the cause to insect bite while asleep. Efforts to obtain night blood is not well countenanced and the diagnosis of Filariasis is ridiculed especially if the patient happens to belong to the fair sex.

One case belonging to the latter category mimicked Quincke's (angio-neurotic oedema) disease so closely that for a time it was forgotten that the swellings occurring in various situations were all confined to one limb alone. Is it possible that these swellings be truly allergic in nature the allergen resulting from the reaction of microfilaria on blood though the latter operate with their sheath on and are said to be non-pathogenic ?

C :—DERMAL.

The description of the so called " Focal spots " by O'connor is available in all current literature on the subject needing no repetition here under the purview of this paper but a few cases showed merely localised pruritus with no evidence of lymphangitis—Radiological evidence was inconclusive. Local treatment with novocaine, ethylchloride and Neoarsphenamine group of drugs (such as those that could be injected subcutaneously) failed to confirm lasting benefit. Deep Xray therapy was not tried.

One extremely interesting case of Generalised Pruritus had to be attributed to Filariasis. This case did very well on intravenous Neo-Salvarsan (3 Injections of 3 grs. each at weekly intervals) though there was no evidence of any form of spirochaetal infection.

(To be continued.)

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CASE REPORTS.

A CYST IN RELATION WITH THE UNDER SURFACE OF THE BASE OF THE BLADDER.

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Miss. P. aged 23 years, was admitted into the hospital on 24-5-37 with a history of Leucorrhoea. On closely questioning the patient while writing the case notes, it was learnt, that she had been to one or two institutions for treatment. At one place, it was said she had an unruptured hymen and was advised an operation. This probability could easily have been overruled as the patient gave a definite history of menstruating regularly. But then there is a possibility of a good portion of the hymen remaining at the posterior aspect of the vagina, without atrophying and leaving a small opening, through which the menstrual fluid may flow. At another, she was told, she had a cystocele. It is difficult to conceive, how a cystocele could form in a nullipara.

The vaginal orifice appeared to be very narrow for naked eye inspection, but when the finger was pushed through the narrow opening near the fourchette, it was found that there was a swelling in the anterior wall of the vagina, which tended to project out through the vagina and partially block the vaginal orifice. On closer examination, it was found to have a cystic feel and in close relation to the base and neck of the bladder as also the beginning of the urethra. To make sure, that the swelling had no connection with the bladder all the urine was drawn out by means of a catheter, when it was noticed that the size of the swelling was in no way diminished. 1 or 2 ccs of acriflavin, solution was injected into the bladder and the catheter removed.

With a finger in the vagina, almost reaching the anterior fornix and by a sort of milking process, the cyst was made tense and about 20 cc of fluid was aspirated with an ordinary 10 cc Syringe from this cyst. The fluid was almost like synovial fluid in appearance and the acriflavin injection into the bladder, had not in the least, coloured the contents of the cyst. With an idea of obliterating the cyst cavity, 7 to 8 drops of Tr. of Iodine, were injected into the cyst cavity. After the aspiration, one could get a good look into the vagina and it contained a good deal of thick, viscid mucus, probably

due to a chronic vaginitis and the inefficient drainage of the canal brought about by the cyst filling up almost, the entire vaginal orifice.

Douches twice daily were ordered for her for a few days. As, by the third day, the cyst had once again filled up to the original size, operative interference was finally decided upon.

Cystoscopy was performed, but the ureteral orifices could not be made out because of the bulging caused by the cyst at the base of the bladder.

On 7-6-37, she was operated on under general anaesthesia.

Operation notes from the Register.—The cyst was in relation to the under surface of the urethra and base of the bladder; about the size of hen's egg; contents: Glairy fluid.; No connection into the bladder; Removed through the vagina. Excised also the redundant mucous membrane. The final appearance of the wound was exactly like that of an anterior Colporraphy wound.

The patient left the hospital with the wound perfectly healed.

I have not come across any mention of a cyst in this area in the literature, and hence the interest in this case.

A CASE OF CHOLECYSTITIS.

By

J. A. S. MASILAMANI, M.B B.S.,

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Name—R. Hindu Brahmin—Age 22½ years.

Admitted on.—25—4—'37 in Dr. T. Satakopan's wards.

Discharged on.—10—5—'37.

Complaint.—Fever. Duration—3 days.

Family History.—Nil particular.

History.—The patient was preparing for his examination in March. On the 21st of March at about 3 a.m., he felt a burning sensation during micturition and also the urine was coming only drop by drop. Since it was dark, he could not notice the colour of his urine. The same morning at 6 a.m. he again passed urine. This time also there was the burning sensation and the urine came in drops, but at the end of the act he noticed 2 or 3 drops of blood. Throughout that day he was passing blood in the urine. That

evening he consulted his doctor and got some mixture. The 3rd day the blood stopped, but the burning continued for a week. On the 31st March evening he got high fever with rigor. The fever was continuous and he had pain in the chest and upper part of abdomen. He got admitted on the 6th April. In two days his temperature came down to normal and he was discharged on the 10th of April. At home again on the 11th evening he got fever with rigor. He again got into the hospital on the 12th. The fever came down after 4 days. He was discharged on the 19th April. Again on the 20th evening he got fever with rigor. The temperature used to come down slightly in the mornings and go up in the evenings. On the 25th he got delirious and was admitted into the hospital at 7-15 p. m.

General condition.—Patient is a fairly well nourished young man, anæmic, and complains of pain in the right loin.

Alimentary-system.—Tongue coated, Teeth clean, Liver and spleen not palpable.

Respiratory system.—Definite dullness over the right base. Breath sounds feeble.

Other systems.—nil abnormal.

Investigations :—

26/4 — *Urine* Sp: gr. 1018, alkaline. Sugar and albumin nil.

— Deposit. { Phosphates +
Few pus cells +

2/5 — Sp: gr. 1012, alkaline. Sugar and albumin nil.

— Deposit. { RBC +
Pus cells +
Few bladder epithelial cells

5/5 Paracolon group of organisms grown in culture. Guinea pig inoculated (No. 68).

6/5 — Urobilin—absent } Result negative for Tubercle Bacilli.

26/4 — *Blood*, no parasite found, no Leucopenia, Total W B C — 10,315 per C-mm. *Diff-count* (2/5)

Polymorphs	—	82%
Lymphocytes	—	11%
Mononuclears	—	6%
Eosinophiles	—	1%

4/5 Blood culture	—	negative	
Widal	—	negative	B. Typhosus. 1-25 positive Para A. B & C. negative.

Faeces. 6/5—No ova or cysts foun.

28/4—*X-ray chest*—Hilar glands of increased density on both sides. Right apex of slightly increased density, costal cartilages show early calcification. Aortic region appears broadened. 4/5—Fibrosis both lungs.

X-ray after administration of shadocol: gall bladder enlarged and shows delayed emptying.

Treatment:—Treatment with alkaline mixtures did not produce any effect. Patient was getting high rise of temperature with rigors. Later when a diagnosis of cholecystitis was made, patient was given the following mixture: Hexamine gr. 30, Soda bicarb gr. 40 soda salicylas gr. 20, tds: The temperature came down to normal and kept normal for the rest of his stay in the hospital.

The interesting feature of the case was the way it simulated an infection of the urinary tract, *viz.*, the fever with rigor, the hæmaturia, and the presence of pus cells in the urine.

Press Note. No. F. 139/2/37-G.

The General Medical Council of Great Britain have recognised for registration the Medical qualifications of the Calcutta University granted on or after October 16, 1936, the date on which the Medical Inspectors of the Medical Council of India completed the re-inspection of the Carmichael Medical College and Hospital, and declared that the facilities provided by the College might be considered adequate.

Consequent on the separation of Burma the Executive Committee of the General Medical Council have been advised that any application for the recognition of diplomas granted by the Rangoon University should in future form the subject of direct communication between the authorities of the University and the General Medical Council. It is understood that the General Medical Council are taking steps to invite the attention of the authorities of the Rangoon University to the appropriate procedure.

(*Medical Council of India*, Simla, the 20th July, 1937.)

RURAL MEDICAL RELIEF.

Mr. K. Vittaldas Pai, Rural Medical Practitioner, Pallavaram, Chairman of the Reception Committee, welcomed the Surgeon-General, the President-elect and the delegates.

In the course of his address, Mr. Vittaldas Pai said that it was about twelve years ago that the late Raja of Panagal started the Rural Medical Relief Scheme. At that time the finances of the Government were not bright and it was agreed to give a small subsidy to the rural medical practitioners. Now when the finances were better and money was available for rural reconstruction work, the Government could certainly increase the subsidy. The Rural Medical Practitioners' Association was started, a few years after the introduction of the scheme, by the late Dr. S. Ramasubbu. For want of support from the practitioners themselves, the Association could not do any tangible work. After Dr. Ramasubbu's demise some of the members felt that the Association must be revived and the present conference was the result of that feeling among the rural medical practitioners that their position must be made more secure from the onslaughts of officials at the head of District Boards and departments of the Government, so long as they were doing their work conscientiously. The agreement which the rural medical practitioners had to sign under penalty of losing their subsidy brought their service into line with regular Government service but without the advantages pertaining to it. Some of the practitioners felt that if the Government were keen on the service being made a pucca one, they ought to pay the practitioners at least a minimum of Rs. 100 per mensem, with provision of a decent dispensary building and ward attendant, better leave regulations and fixity of tenure. But the practitioners desired to be governed by the original idea of independent subsidised medical practitioners, under which they should have liberty to practise anywhere in the afternoons and come back to the station in the night. They should have opportunities to discuss topics concerning village reconstruction with official and non-official agencies, with freedom to take part in civic and political affairs.

Mr. Vittaldas Pai next requested Major-General Sir Frank Connor to open the conference.

SIR FRANK CONNOR'S SPEECH

In declaring the conference open, Major-General Sir Frank Connor said that he had been told that only about 25 rural medical practitioners were present at the conference. He knew how difficult it was for many and most of them to go to Madras from the mofussil. The Surgeon-General proceeding said that ever since he had come in their midst he had a very soft corner in his heart for the rural medical practitioners and for rural medical practice. That was not only because he had a soft corner for them

but because of the necessities of countless numbers of people in rural areas who to a great part were untouched by medical aid. It was a very difficult thing for the Government or the Surgeon-General to grapple with such problems. They had in this province a population much greater than that of the United Kingdom. A great many of them were very poor and it was not possible for the Government to give free medical aid to all the poor people in this vast province. That problem had been exercising his mind very much. Whenever he had gone to districts and attended District Medical Associations, he had always wanted to know how rural medical practice was getting on. He had not come there to listen to their grievances. There would, he was sure, be a certain number of resolutions passed presently which would have his best attention. But the chief function of that meeting was for them to meet each other, talk over their difficulties, see in what reasonable ways they could be ameliorated,--in other words to take stock of their conditions and make wise plans for the future. The Surgeon-General would help them; the Government would help them. But the problem was a very difficult one. He had dropped in at many rural medical practitioners' homes. He had first-hand information of them and their conditions. For the most part whenever he had asked them how they were getting on, they had told him: "Not too badly; we do not make much money; we are pulling along, Sir." That was the expression but that was something. They must remember that if they chose rural medical practice, it meant a certain spirit of service which they could not get away from Anywhere in the world, the doctor, fortunately or unfortunately, had a great deal to do for nothing. That might seem hard. But on the other side they did learn much from their patients. Further it was invaluable in that it inculcated in them from the beginning that spirit of service without which the doctor was very poor indeed. Until the individuals in rural areas became more prosperous the doctors would not be in a position to get much in the way of fees. That was the stern fact. But every indication was present that the time had come when the condition of rural areas and people living in rural areas was going to be looked into more fully and help given them.

An Experimental Measure

"I think," said the Surgeon-General, "rural medical practitioners are very intimately connected with these Economic Councils which have been started in the districts. In this province we have 400 and odd rural medical practitioners of whom a majority have the L.M.P. qualification, a few are graduates and a few licentiates of the Indian Medical School. This whole service of rural medical practitioners is an experimental measure and this is the only Province in India where up to now it has proved a comparative success. I cannot say it is a complete success, as many of you

say you are just pulling along. In Bombay they just tried informally. In Burma they started it three years ago and they said it was hopeless and were going to give it up. This is the only province in India where on a fairly large scale—not the scale we want—this service is being given more than an experimental trial. It rests with you more than on any one else to make this experiment a success or not. If you say you have too many grievances the Government will have to say that the scheme is a failure."

Proceeding, the Surgeon-General said that they had had till now five conferences. Some of them brought them some good fruits. Many had just passed resolutions on grievances. All of them had grievances He had plenty of them himself. Grievances would not help them, unless they were reasonable. There was a fallacy in their argument that they wanted little control over them. Perhaps they felt that they had more control than they liked to have for the comparatively low subsidy they obtained. Under existing circumstances it was very difficult in most rural areas to make good enough living without help. Possibly they felt that the triple control, namely of the District Board, the District Medical Officer and of the Government made their position difficult, particularly in political times. Politics was likely to come into many matters and if their controlling powers were more than one, their position and prospects were likely to be affected. But the Government were not likely to give them subsidy without control over them; so also the District Boards. He would repeat again that it would not do for them to harp upon their grievances too much. Let them take advantage of this meeting, get to know each other better, and try and work out in what way they could improve themselves and above all try and be of help to Government by trying to define what is the best way medical relief to the far distant rural areas can be given.

Spirit of Service

Concluding, the Surgeon-General said: "We doctors have been taught to give relief to the poor for nothing. The spirit of service must never leave us. But we are not all missionaries. I think the predominant note must always be that of a certain amount of sacrifice on your part towards the problems of India, and I say that until individuals, young individuals, give a great deal of their time and leisure and service for the country, it will get on very slowly. Thousands and thousands of young men in other countries are working like coolies in labour camps, to turn marshy lands into cultivable ones. That is the sort of thing that makes a country go ahead. When that happens in India, India will go ahead and you have a share in that picture."

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JULY, 1937.

THE RURAL MEDICAL CONFERENCE.

We are glad that the subsidized rural practitioners of this Province have been able once again to come together to take stock of their needs and duties. After the untimely demise of Dr. Ramasubbu the late Secretary of the Rural Medical Practitioners' Association there has been a lull in the propagandist activities of the vast body of the rural practitioners. As every one from the President and the Surgeon-General downwards realized at the Conference, successful medical relief of this country depends on the contented services of the medical men distributed over the thousands of villages. Till recently the few medical men that were available have been grouped round the city of Madras and important district and taluk head-quarters towns. Since entry into the various Government services has been curtailed and since a larger number of medical men and women qualify from the various colleges and schools, medical men have naturally been turning their attention to the hitherto badly neglected rural parts. It was at this psychological moment that the far-seeing statemanship of the late Raja of Panagal introduced the idea of subsidizing medical men to settle down in the villages. As often happens in this country, with the disappearance of the author of the scheme, the scheme has been allowed to languish. Lack of funds is pleaded by the Government. This is said to prevent them from opening up new centres of rural medical relief and otherwise enlarging the scope of the scheme which is said to be very close to their hearts. We fully appreciate the distress of the spokesmen of the Government. But we venture to suggest that all their anguish has not been enough to make them halt and look round to see if they have exhausted all human ingenuity to slice out a moiety of the

expenditure on the medical department to be utilized for encourging some more medical men to go to the villages.

We are well familiar with the plausible arguments that are usually advanced. We are often told that the limited resources are spent on the essential needs. On analysis, these essential needs often turn out to be costly buildings designed inconveniently, with little reference to present needs and with no thought for even the near future. The next essential is considered to be expensive medical staff. We do not suggest that medical men are not worthy of their emoluments. We refer to the needless overlapping of duties and incompatible appointments. On a careful scrutiny, we are sure that some of the expensive offices could be abolished, others amalgamated and many more could be as well held by less paid staff without loss of dignity or efficiency.

Even more important than this monotonous cry of paucity of funds is the utter lack of plan or philosophy in the organisation of medical relief in the Province. In concert with what takes place in other countries, particularly in Great Britain and America much apparent homage is paid to the greatness, importance and usefulness of the general practitioner, including the subsidized rural practitioner. But in reality, every line that is written of them and every word that is spoken to them brims with snobbery and patronage. This is very marked in this country where every medical man drawing a big salary from the State or private concerns is encouraged to consider himself a specialist, senior or junior. Even heads of departments are not sometimes free from this attitude of amused and self-satisfied superiority. If it is true that the general practitioners in the town and subsidized practitioners in the outlying villages are really the backbone of medical relief, it is unthinkable that earnest attempts should not have been made to make their work more attractive and their lives a little less joyless.

The humble practitioners in these villages have many grievances, some of them real and, may be, others unreasonable. It is the duty of a wise and interested Government to investigate

these grievances, rectify the defects and reassure the practitioners on other points. This is how the British Government treats the National Health Insurance Scheme From its inception there have been complaints. The British Medical Association has submitted many memoranda with interminable grievances and led many deputations to plead with the Government The Government has responded to these activities by introducing modifications from time to time to meet the practicable demands of the profession. At no stage have they told the practitioners "Take the scheme as it is or leave it".

We regret very much that the Surgeon-General with the Government of Madras should have given expression to sentiments very much akin to *take it or leave it*. He has in a way dangled the sword of Democles over the heads of these practitioners. In effect he said that if the subsidized practitioners were to give a catalogue of grievances, he will be compelled to advise the Government that the scheme has been a failure, evidently implying that if grievances are expressed the scheme should be scrapped. What a contrast to what obtains in England! To our knowledge, the British Medical Association has a string of complaints and condescends to compromise with the Government. They have never advised the Government to scrap the scheme, nor does the Government threaten to do so in the face of complaints. Why is the Surgeon-General so forgetful of the history of his own Service, the Indian Medical Service, in the recent past? The members of this Service had innumerable grievances to publish before the Public Service Commission of 1912 and to the Lee Commission more recently. We are not sure if they are not having grievances even now. How would he have liked it if the Government of India and the Secretary of State in England had said that if the complaints were loud they would be compelled to advise that the I.M.S. was a failure and hence should be abolished? Verily an illustration of what is poison to the one is honey to the other!

Indeed the rôle of rural practitioners is hard and difficult to sustain It is not lightened by such sentiments of the head

of the department. We are sure the practitioners realize the difficulties and the limitations of their environment. They would gladly and bravely give their services to the neglected people in the villages for what little remuneration they could get. But they would like to be saved the insulting advice that is often so glibly held out to them by more fortunately placed individuals. It stings them to fury when they are exhorted to cultivate the missionary zeal in their work. The example of foreign missionaries is held out to them, of people who have decent quarters to live in and who have not to trouble about the wherewithal to live the next day Such words are out of place addressed to people to whom the struggle for existence is a reality and not a legend.

Still, in spite of everything said there is no need for the rural practitioners to take too tragic a view of their work They have many depressing difficulties. They have also a few advantages. Some of them might believe that the lot of the practitioners in towns is much better It is not true. The majority of them struggle hard to maintain themselves with self-respect The difficulties of the rural practitioners are local and personal. They vary from place to place and from person to person. Many of them are beyond the interference of the Government. The Surgeon-General with the Government may feel helpless. But we think that most of these difficulties could be got over by the zeal for work and tactful conduct of the practitioners themselves. When earnest work is not appreciated and tact fails to persuade, then it would be time for the medical men to appeal to the public for help. We earnestly hope that the rural practitioners would respond to our appeal.

Ring, bells, ring!

Members of the Union and the readers of this Journal would feel very glad and proud to know that for the first time in the history of the Government of this Province two members of the Medical Profession have been called to occupy high office in the Government.

Dr. U. Rama Rao who has been elected to be the President of the Legislative Council is one of our respected office-bearers. He was President for a term and he has been Vice-President for a number of terms. His services to the public and the profession are well known. We wish him great success in the new sphere of his activities.

Dr. T. S. S Rajan who is the Minister of Public Health, though not so well known to the profession, has been in the public life for a number of years. His membership for a short period in the Central Legislative Assembly has been distinguished by his keen interest in the Medical Services. We are sure that his varied experiences as a busy practitioner in one of the mofussil headquarters towns and his knowledge of the difficulties of the private practitioners of this Presidency, would stand him in great stead in handling with success the many problems of administration and policy which are likely to arise in the course of his office. The Medical men feel that all branches of the profession will get a fair deal from such an enlightened and experienced member of the profession. We wish him god speed in his new task.

GLEANINGS FROM MEDICAL LITERATURE.

12. CYSTIC HYGROMA.

HAMILTON BAILEY,

The Clinical Journal, June 1937, Pp 242 et seq.

Cystic Hygroma consists of an aggregation of cyst-like spaces the larger lying near the surface and the smaller cysts deeply and tending to infiltrate the muscle planes. The cysts are lined by a single layer of *endothelium* and filled with clear fluid so that the swelling is brilliantly translucent. Nine tenths of Cystic Hygromata occur in the neck or axilla, the neck occupying the pride of place. The general consensus of opinion is that these tumours are due to aberration of the lymphatic system and are of the nature of retention cysts.

Clinical features: Appear during early infancy and are occasionally present at birth. Situated typically in the lower third of the neck passing upward towards the ear as they enlarge. Lie lateral to the carotid sheath and anterior to the cervical nerve roots often extending down below the clavicle to lie over the dome of the pleura.

Clinical behaviour is uncertain :

(1) May grow with great rapidity, suddenly burst subcutaneously and disappear.

(2) Become the seat of recurrent attacks of inflammation which resolves without any special treatment.

(3) May grow up to a point and become stationary.

(4) Exceptionally, become malignant.

Management and treatment: The mortality among infants with Cystic Hygromata is high and this has in many instances been the result of active treatment.

The best treatment appears to be to hold one's hand until the child has reached the age of two and is strong and healthy when a clean dissection of the entire mass yields excellent results.

M. K.

13. DIAPHYSECTOMY IN ACUTE OSTEOMYELITIS.

A. L. D'ABREU,

Lancet, 19-6-1937, Pp 1454 et seq.

Author's Summary: Diaphysectomy is rarely required in the treatment of acute osteomyelitis since the results of conservative incision of a subperiosteal abscess are good, when combined with general and local rest. In common with the other radical measures it is unavailing when fulminating septicaemia overshadows the local lesion.

Extensive periosteal stripping does not imply certain necrosis, but when combined with true myelitis the shaft will largely die; in such patients resection diminishes sequestrum formation and provides splendid drainage of the pus in the periosteal tube. The gutter operation is unsound for it does not save sequestration nor provide adequate drainage; it is based on the faulty assumption that bone rigidity is the important factor in acute osteomyelitis.

The theoretical objection that a valuable source of calcium is removed by diaphysectomy overlooks the inability of avascular bone to yield or acquire calcium. The operation is unjustifiable in infants and adults the optimum age being 6—16 years. The procedure, except in the case of the fibula where it is the operation of choice, must not be adopted until simple periosteal and metaphyseal drainage have failed and then only when there is certain proof of myelitis. An adherent periosteum requiring instrumental separation contra-indicates resection.

The results in seven patients have been satisfactory. The epiphyses must be conserved and the resection need not proceed 1″ beyond the affected portion of the shaft. The periosteum must be meticulously preserved and adequate immobilisation provided.

M. K.

14. LOBECTOMY FOR BRONCHIECTASIS.

L. S. T. BURRELL,

Medical Press and Circular, 23rd June 37, 589.

In the opinion of the author the only *cure* for Bronchiectasis is excision of the diseased part, *i.e.*, lobectomy or pneumectomy. The mortality from these operations has under modern technique been considerably reduced

and probably they will become standard treatment for Bronchiectasis. At the same time simple medical treatment by some method of postural drainage is effective in a considerable number of cases and even in some advanced bilateral cases and there is far more chance, than is generally supposed, of the patient becoming free from the most objectionable symptoms as a result of simple medical methods. As in many other conditions it is a matter of the balance of risks and the risk of lobectomy being still considerable one must not advise treatment which is more dangerous than the disease it is intended to cure.

If it is decided to operate preliminary treatment is of the utmost importance. Toxaemia, anaemia and debility should be corrected and one or more bronchoscopic aspirations performed to get rid of excessive offensive secretion. Phrenicectomy before or during operation is advocated by some. Thracoplasty is not good except after pneumectomy, if the pleural cavity remains unclosed due to expansion of the other lung.

Lobectomy is indicated if haemoptysis is severe or repeated, where there is purulent offensive sputum and in children with bronchiectasis resulting from atelectasis. It is not to be advised in cases of dry Bronchiectasis found accidentally by Xray after the introduction of Lipiodol. Artificial pneumothorax is unsatisfactory and indeed the presence of large areas of adherent pleura may make a satisfactory collapse almost impossible. Thoracoplasty is disappointing and Phrenic avulsion useless if not positively harmful.

M. K.

15. MYOSITIS OSSIFICANS TRAUMATICA.

RALPH F. BOWERS,

Journal of Bone and Joint Surgery, Jan. 1937, 215.

Three types of cases require consideration in the treatment :

(1) *The most frequent type,* following minor injuries to the thigh or buttocks in which small calcified symptomless areas are discovered. These require no treatment.

(2) *The second type* with extensive calcified areas with definite symptoms, a tender mass and sometimes a certain amount of disability. Usually during the period of 5-12 months following the appearance of the

mass gradual absorption and ultimate disappearance with recession of symptoms takes place.

(3) *The third type* of cases with the mass usually located in the region of the joints disabling the patient by ankylosing or limiting joint movement and in which after a proper period of observation, absorption does not occur. This type is not very frequent and requires operation.

In the conservative attitude to the condition a time limit of waiting for spontaneous absorption has been suggested. On the other hand sarcomatous change following an apparent myositis ossificans has been described and where doubt of the true nature of the condition exists it is perhaps unwise to delay biopsy.

M. K.

16. CLINICAL INDICATIONS FOR THE USE OF THE SPECIFIC HARMONE OF THE CORPUS LUTEUM.

C. CLAUBERG,

The practitioner, May 1937 Pp 634.

The chief clinical conditions due to Corpus Luteum deficiency are:

(1) The condition termed *glandular cystic hyperplasia* of the endometrium which occurs most frequently in young girls and elderly women. It is due to the persistance of a graffian follicle and the follicular harmone secreted by it produces an excessive and protracted hyperproliferation of the endometrium. This leads to bleeding which is not only irregular but may be very copious. The amount of harmone to be supplied varies: as little as 1-2 mgm. per day may be adequate or as much as 5-20 mgm. daily may be required and treatment should be continued for at least 10 days. Actually the most logical method of curing these cases of glandular cystic hyperplasia is to produce luteinisation of the persistant follicle or to destroy it but there are at present no means of doing so although direct transfusion of the blood of pregnant women has proved a method of great value.

(2) Other forms of irregular hæmorrhage often loosely termed "functional."

(3) Habitual early abortion. Corpus Luteum harmone is necessary for the normal maintenance and development and modification of the endo-

metrium and nidation of the ovum until such time as the placenta is sufficiently developed to be able to function as an independant organ. Before this event however its elimination or absence leads to abortion and artificial administration is capable of preserving the pregnancy during the critical period.

(4) Threatened abortion due to trauma, as the Corpus Luteum harmone inhibits the contraction of the uterine muscle.

(5) Habitual late abortion or premature labour. The rationale of this is based on the known factor that Luteal harmone is present in the placenta. It would appear that the mature placenta takes on the function of the Corpus Luteum in later pregnancy since luteal harmone appears to be necessary even during the later stages of gestation. It is of course imperative that other causes of late abortion, especially syphilis are eliminated.

M. K.

REVIEW.

We have received a copy of Essential and Common place Aspects of Heart Diseases kindly sent to us by the well known firm Messrs. Knoll A. G. Pharmaceutical chemist through their Indian agents Martin and Harris.

This has been specially written to commemorate the fiftieth anniversary of the foundation of the house of Knoll by Dr. Karl Fahrenkamp, Struttgart. The author has given a resume of his twenty years' personal experiences of heart disease, heart patients and experimentally proved and pharmacologically established methods of treatment. Readers will find in this booklet many hints that may be of use to them in their practice.

ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION

Under the auspices of the Union Dr. P. Rama Rao gave a Cinema demonstration of "The Mechanism of the Heart in Health and Disease" on Monday the 5th July 1937. The meeting was held in the Medical College Hall. The meeting was well attended and the demonstration was very instructive and much appreciated by the audience.

A special vote of thanks was proposed and passed before the meeting dispersed.

GUNTUR DISTRICT MEDICAL ASSOCIATION

The second anniversary of the Guntur District Medical Association came off on 29th June '37 at the premises of the Government Training School under the presidency of Capt. Davis, I.M.S., District Medical Officer, Guntur, before a large gathering of both official and non-official medicos from all parts of the district.

Capt. Davis, in the course of his preliminary remarks, drew attention to the existence of a parallel association in Guntur and wished that both the association were amalgamated and began to do some useful work. He said that in a place like Guntur, there was so much of scope, and it was a great pity that medical men could not come together for common purpose. He urged that the Association also affiliated itself to the All-India Medical Association. The two local associations must work together in harmony and all differences that existed before should be forgotten.

After election of office-bearers for the coming year, in which Capt. Davis was re-elected President, the function came to a close with a vote of thanks.

TUTICORIN MEDICAL UNION

The third anniversary of the Tuticorin Medical Union was celebrated on 29th June '37 in the S. A. V. School premises. At 4-30 the members were entertained to tea. A public meeting was held under the presidency of Dr. K. Srinivasaraghava Iyengar, Civil Surgeon and President-Founder of the Union.

The Report and audited accounts of the Union were then read and presented by Dr. V. K. Seshadri, L. M. P., Secretary of the Union.

Dr. Noble, Chief Medical Officer of the Catherine Booth Hospital, Nagercoil, delivered a lecture on "Recent advances in Medicine and Surgery." He referred to the modern treatment of glaucoma, the practical details of the operation and then referred to the use of radium in the treatment of many diseases and of the advances made in the direction as of using rays emanating from radium through tubes, the advanced shock-proof X Ray apparatus and its advantages, etc.

With a few concluding remarks from the chair and a vote of thanks proposed by the Secretary the function came to a close with a dinner in the night.

KURNOOL DISTRICT MEDICAL ASSOCIATION

The meeting of the District Medical Association was held in the premises of the Government Headquarters Hospital on the 29th June '37. Mr. E. A. Varada Aiyar, D. M. O., presided. The minutes of the last general body meeting was read. Dr. O. Subramaniam read a paper on " Critical survey of metabolic diseases ". The meeting terminated after a dinner at the District Board Buildings.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION PALAMCOTTAH

(*Affiliated to the Indian Medical Association*).

The Tinnevelly District Medical Association held its monthly meeting on Saturday the 26th of June 1937 at PAPANASAM, one of the most sacred places of the District, noted for wild scenery and most charming water-falls.

Members numbering 42 including 3 lady doctors gathered from all parts of the District. All the members had an early bath at the Falls and which was followed by light refreshments.

The Meeting began at 9 30 a m. under the Presidentship of Dr. K. Srinivasaraghava Iyengar, L. M. and S., Retired Civil Surgeon. The Secretary read the minutes of the last monthly meeting held at the Head-quarters (Palamcottah) on the 29th of May 1937, which were passed.

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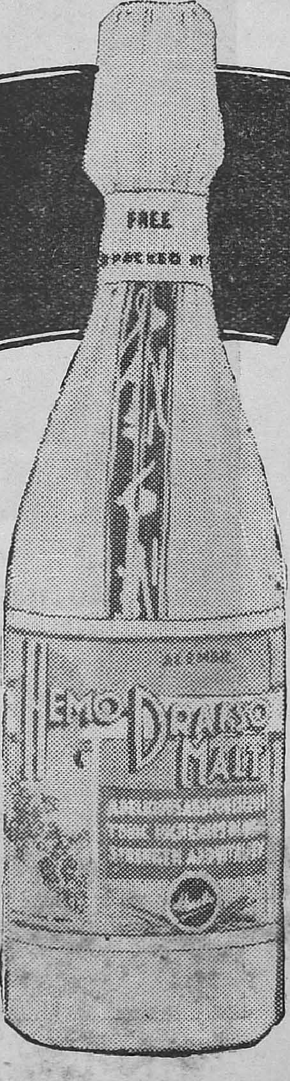

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Dr. T. V. Gopala Menon, M. B. B. S., of the Ambasamudram Hospital, read out an interesting short address on Penetrating wounds of Abdomen He also demonstrated a case of dextro-cordia to all the members. Dr. P. S. Srinivasan, L. M. P. of the Government Headquarters Hospital, Palamcottah, read out clinical notes of the following interesting cases which were successfully operated and treated at the Government Headquarters Hospital, Palamcottah, and at the Government Women & Children Hospital, Vannarpet by Lieut. Col., T. S. Shastry, I. M. S :

1. A case of Appendicitis.
2. Acute inversion of uterus with submucous fibroid.

The following specimens in connection with the above cases were also shown to the gathering :—

1. Appendix.
2. Submucous fibroid uterus.

After detailed discussion by the members Dr. K. Srinivasaraghava Iyengar, L.M. & S., summed up the salient and important features of all the cases He also narrated briefly his reminiscences about various important cases during his long experience. He offered his cordial thanks to all those members who helped towards the success of the function and thanked Dr. T. V. Gopala Menon, M.B.B.S., for the excellent arrangements.

The members were warned about the prevalence of diphtheria in Tinnevelly as a case was admitted to the Headquarters Hospital two or three days ago and they were requested to be on the look out for such cases.

During the interval there was excellent Music.

Thereafter, an excellent Dinner brought the happy gathering to a close at 2 P. M.

HEALTH EXHIBITION

Under the auspices of the Tinnevelly District Medical Association in connection with its monthly meeting at PAPANASAM, a Health Exhibition was arranged at the Catholic School, Uchangulam, at 5 30 P. M. the same day. This was the first time a Health Exhibition was arranged at this place for the benefit of the Mill labourers and staff and their Families.

The Exhibition was kept open till late in the evening and also for the following day for the benefit of labourers, Staff and their Families and also for the School children. The exhibits consisted of posters relating to Cholera, Tuberculosis, Malaria, Small-pox, Fly danger, Venereal Diseases, etc.

This was very much appreciated by the gathering.

PUDUKOTTAH MEDICAL ASSOCIATION

The monthly meeting of the Pudukottah Medical Association was held on Friday the 25th June '37 evening in the General Hospital premises. Dr. B. Narayanaswami presided. Dr. V. Sadasivan spoke on "Climatic Bubo and allied conditions".

SOUTH ARCOT MEDICAL ASSOCIATION

A meeting of the South Arcot District Medical Association, Cuddalore, was held on 19th June '37, at the premises of the Government Headquarters Hospital here. Dr. C. S. Ganapathy Aiyar, District Medical Officer, presided. A large number of medical practitioners from all parts of the district attended. At the outset certain matters regarding the management of the Association were discussed.

A resolution was passed congratulating Dr. S. Padmanabha Sharma, the previous District Medical Officer, who has been transferred to Madura, on his having been conferred the title of "Rao Bahadur" by the Government, during the Coronation of His Majesty.

Dr. Ganapathy Aiyar delivered a long and interesting lecture on "Some Common Diseases of the Ear".

The members were then entertained at tea by Dr. Ganapathy.

ANANTAPUR DISTRICT MEDICAL ASSOCIATION

A meeting of the Anantapur District Medical Association was held, on the 19th June '37, in the premises of the District Headquarters' Hospital, with Major Krishnamurthi, District Medical Officer, President of the Association, in the chair. Medical men from Uravakonda, Hindupur, Pamidi and other places were present.

After tea, Dr. Nithyanandham, District Health Officer, delivered a lecture on "Cholera".

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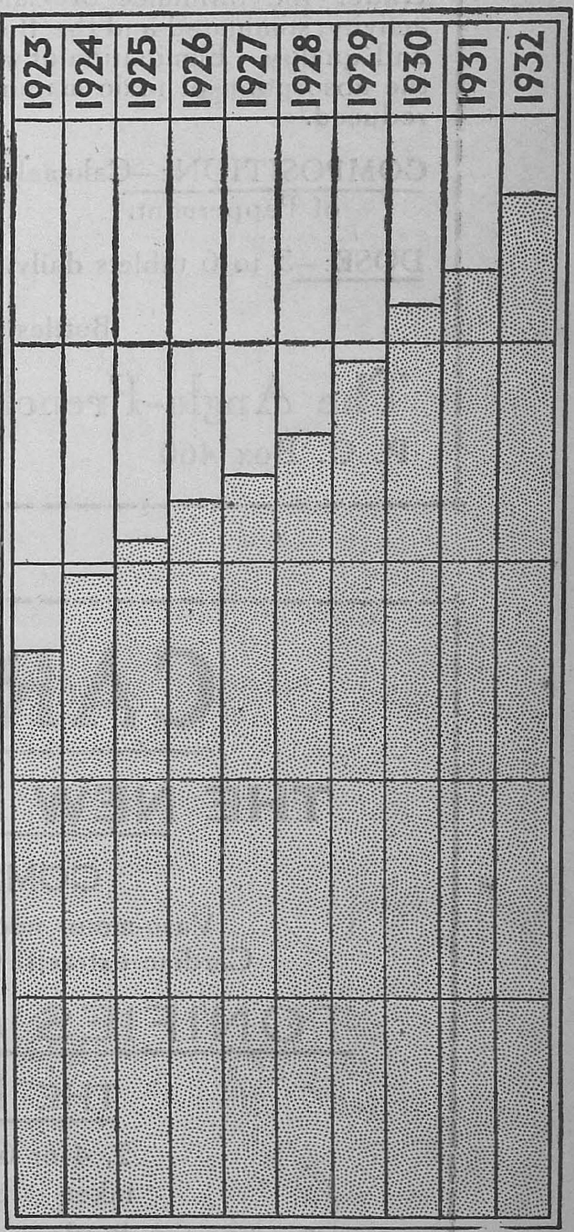

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At the invitation of Dr. Varadarajulu Naidu, Doctor at Hindupur, the members decided to meet on the 24th of next month at Hindupur, when Dr. Sreenivasa Rao, Resident Medical Officer, will deliver a lecture on some special aspects of the " Eye ".

TRICHINOPOLY MEDICAL ASSOCIATION

A monthly meeting of the Medical Association was held on the 19th June '37 in the E. R. High School, when Drs. K. Bakthavatsalam and M. K. Pathmavathi Ammal were " At Home " to the members. Dr. Mrs D'Costa L. M. and S. presided.

After demonstration of clinical cases, Dr. N. C. Subramanyam Hon. Tuberculosis Specialist, delivered a lecture on " Pulmonary Tuberculosis ". A discussion in which many members took part followed.

COIMBATORE DISTRICT MEDICAL ASSOCIATION

The monthly meeting of the Coimbatore District Medical Association was held on 15th June '37, at the X-Ray Room of the Government Hospital.

After tea, Dr. Ackroyd, Nutrition Expert to the Government of India at Coonoor, delivered an address on ' Nutrition '. Lieut.-Col. T. S. Shastry, District Medical Officer, and President of the Tinnevelly Medical Association, presided, Rao Saheb Dr Y. P. Vasudeva Aiyar, President of the Coimbatore Association, in proposing Col. Shastry to the chair requested him to talk to them on the benefits of a medical association.

The President, in his opening remarks, observed that the sign of the activities of the profession really was reflected in the degree to which an association like theirs was able to work. He was glad to learn that the Coimbatore Association was a District Association and that the office-bearers were almost all of them independent practitioners. He felt that there should not be any cleavage between the service element and the independent practitioners. On the other hand there should be hearty co-operation between the two sections. He congratulated the Association on their decision of have a building of their own. He then went on to describe the activities to of his own Association in Tinnevelly. He favoured the idea of the Association meeting once in a way at least in moffussil towns thereby coming into contact with rural practitioners and learning their problems and wished that there should be collaboration between the several neighbouring district associations.

Dr. Ackroyd in his address on 'Nutrition' dwelt on the importance in the diet of children and the expectant nursing mother. A diet based exclusively on grain foods or cereals was not the best and he stressed the importance of including milk in the diet. He recommended hand-pounded rice in the place of milled rice and urged that great attention should be paid to the diet of school-going children suffering from malnutrition. He then described through charts the prevalence of various deficiency diseases and said that a large percentage of sickness in India and in the east was directly or indirectly due to faulty diet The welfare of the poorer classes was very closely dependent on diet. On the practical side the medical profession could play a part in combating malnutrition. By educating the people on the diet to be given to young children progress could be attained. He recommended the health bulletin issued by the Government of India showing the amount of malnutrition prevalent in the country and the table of about 200 varieties of commonest Indian foods for their study.

Questions were then put and answered.

Dr. Sampath, the Secretary, proposed a vote of thanks.

The Coimbatore District Medical Association has purchased a site measuring 53 cents at Rs. 25 a cent for Rs. 1,326 from the Coimbatore Municipality for constructing a building. The site has been given by the Municipality at a concession rate.

CHINGLEPUT DISTRICT MEDICAL ASSOCIATION

Over 30 medical practitioners from all over the district, including private medical practitioners and the Municipal Health Officers of Conjeevaram and Chingleput, were present on 13th June '37 when Captain C Krishna Menon, Assistant Surgeon, who is now acting as the District Medical Officer, inaugurated the District Medical Association. He invited opinions from all the practitioners and hoped that private medical practitioners in the district would join the Association in large numbers. He announced that circulars would be sent to all in the district inviting opinions.

NILGIRIS DISTRICT MEDICAL ASSOCIATION

At a meeting held in "Grasmere House, on 13th June '37 under the presidency of Lt.-Col. Sastri in the unavoidable absence of the Surgeon-General, the Nilgiris District Medical Association was inaugurated and

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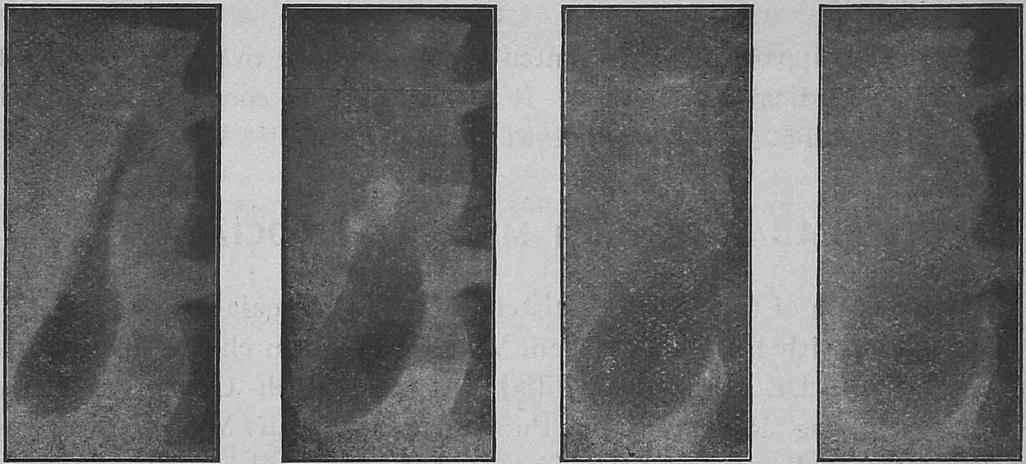

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office-bearers were elected. After tea, Lt.-Col. Sastri stressed the necessity for such an Association.

Dr. Venkappa of Madras wanted the Association to get itself affiliated to the Indian Medical Association. It was decided to consider the question at the next meeting. Office-bearers were then elected.

MALABAR DISTRICT MEDICAL ASSOCIATION

A meeting of the Malabar District Medical Association was held on 13th June '37, with Dr. N. Achuthan, Vice-President in charge in the chair, when Rao Sahib Dr. R. Anandan Pillai, District Health Officer, delivered a lecture on "Some Reflection on Public Health." Dr. Mrs. Barretto, was 'At home' to the members. The President eulogised the services of Dr. V. Krishna Menon, the retiring Secretary, and welcomed the new Secretary, Dr. C. V. Narayana Aiyar.

SALEM DISTRICT MEDICAL ASSOCIATION

A meeting of the District Medical Association was held on the 11th June '37, at Yercaud, under the presidency of Major A. C. Alagappan, I.M.S. District Medical Officer, Salem, and President of the Salem District Medical Association. Capt. Hussey of Yercaud, read a paper on "Venereal Diseases." A discussion followed. The members were treated to tea by Dr. T. M. Natarajan. The meeting then terminated.

NORTH ARCOT DISTRICT MEDICAL ASSOCIATION

The North Arcot District Medical Association was "At Home" on the 6th June '37, in the premises of the Local Government Pentland Hospital, to Mrs. and Capt. Gerard Kelly, I.M.S., District Medical Officer and President of the Association, on the eve of his transfer to Tanjore. A large number of medical practitioners from all over the district attended the function.

Drs. Nathamuni Naidu, R. P. Nathaniel, S. Kanthimathinathan and others made appreciative references to which Capt. Kelly made a suitable reply.